DEPART CENTER	MENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	45t	1 1	5/28/16	FORM	04/13/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	TAQ (EX)	E SURVEY PLETED
	· · · · · · · · · · · · · · · · · · ·	445408	B. WING	;		04/	11/2016
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, 2IP COD		
SODDY-I	DAISY HEALTH CARE	CENTER		į.	SEQUOYAH ROAD DDY-DAISY, TN 37379		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	łOŲLD BE .	(XS) COMPLETION DATE
\$\$=D	A fire alarm system components appropactor and NFPA 72, Natio provide effective was building. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each recuired at exits if required at exits if required at exits if required at all nurse notification is provide signals. In critical of sufficient. The fire alarm automatically the event of fire. The alarm automatically the event of fire. The crecords are mainta 18.3.4, 19.3.4, 9.6 This STANDARD in Based on observation and in Director, on 4/11/16 smoke detectors in therapy were located. These findings were Supervisor and acknowledges and acknowledges and acknowledges and acknowledges.	terview with the Maintenance of at 10:15 AM confirmed the the the front hall and hall by ed too close to air supply. The verified by the Maintenance knowledged by the confirmed on the oxit conforence on	K	951	K.051 1.) The Director of Main relocated smoke detector front hall on April 12, 26 relocated the smoke detector hall by therapy on April 2.) The Maintenance Diraudited the entire facility proper compliance to ensmoke detectors were loleast 3 feet from an air s. April 12, 2016. 3.) The Maintenance Dirin-serviced by the admirensuring smoke detector located at least 3 feet from supply on April 26, 2016 preventative maintenance will include auditing the detectors to ensure that it compliance. 4.) Audits of the prevent maintenance program, winclude the assessment of smoke detectors in relationships, will be performed Maintenance Director days and then weekly weeks and then monthly months and/or until 1000 compliance.	r in the 016, and ector in the 25, 2016. rector y for sure cated at upply on rector was histrator on as were om an air 6. The se program a smoke it is in tative which of the ion to air ed by the aily times times 3 times 2	Wes mark
LABORATOR	Y DIRECTOR'S OR PROVI	DERICUPPLIER REPRESENTATIVE'S SIGI	MATURE		TITLE		(X8) DATE
					Nite	$\boldsymbol{\varphi}$	127116

Any deficiency statement ending with an asterisk (\*) denotes a distinion which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulsite to continued program participation.

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Division of Health Care Fac	ilities	C/20 A 8 H = 101 E .		(X3) DATE SUR	VEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) BATE S' COMPLE A. BUILDING:			TED [	
	TN3315	a. WING		04/13/20	016	
NAME OF PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, ST	ATE, ZIP CODE			
SODDY-DAISY HEALTH CAR	701 SEC	QUOYAH ROAD				
		DAISY, TN 373	79 PROVIDER'S PLAN OF COR	BEATION 3	(X5)	
ARACH GERICIENO	ATEMENT OF DEPICIENCIES LY MUST 8E PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE 💛	OMPLETE OATZ	
			The Director of Maireport results of comsmoke detectors and to air supply audits. Assurance Performa Improvement meeting months or until comachieved. Members committee include in Director, Director of Administrator and Director of Nursing Development, Social Dietary Manager, Ractivity Director, Eand Unit Mangers.	apliance with their locations to the Quality nce ng for 3 apliance is of the Medical f Nursing, Assistant , Staff al Services, ehab Manager, invironmental	5/16/16	

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REFRÉSENTATIVÉS SIGNATURE

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2 OF 10

PRINTED: 04/13/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO, 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445408 B. WING 04/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 SEQUOYAH ROAD SODDY-DAISY HEALTH CARE CENTER SODDY-DAISY, TN 37379 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRËFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) K 051 | Continued From page 1 K 051i 4/11/16. K064 NFPA 101 LIFE SAFETY CODE STANDARD K 064 1.) The Director of K 064 SS≂F Maintenance on April 11, Portable fire extinguishers shall be installed. 2016, removed all obstructions inspected, and maintained in all health care to the fire extinguishers in the occupancies in accordance with 9.7.4.1, NFPA facility. 10. 2.) The Maintenance Director 18.3.5.6, 19.3.5.6 audited all of the fire This STANDARD is not met as evidenced by: extinguishers throughout the Based on observation and interview, the facility facility to determine their falled to ensure fire extinguishers were un-obstructed.(NFPA 10, 1-6.6) compliance on April 12, 2016. 3.) The Maintenance Director The findings include: was in-serviced by the Administrator on ensuring fire Observation and interview with the maintenance extinguishers were undirector on 4/11/16 between 12:25 and 2:00 PM obstructed on April 26, 2016. confirmed fire extinguishers were obstructed in The facility did a staff indietary(2), by the MDS office and the extinguisher service that was completed on in the therapy corridor was hidden by an artificial April 22, 2016, on ensuring shrub. fire extinguishers stay un-These findings were verified by the Maintenance obstructed at all times. Supervisor and acknowledged by the The preventative maintenance Administrator during the exit conference on program will include auditing 4/11/16. fire extinguishers to ensure K 072 NFPA 101 LIFE SAFETY CODE STANDARD K 072 that they are in compliance. \$\$=D 4.) Audits of the preventative Means of egress shall be continuously maintained in maintenance program for free of all obstructions or impediments to full ensuring fire extinguishers instant use in the case of fire or other emergency. stay un-obstructed, will be No furnishings, decorations, or other objects shall performed by the Maintenance obstruct exits, access thereto, egress there from. Director daily times 5 days or visibility thereof shall be in accordance with and then weekly times 3 weeks 7.1.10, 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: and then monthly times 2

FORM CMS-2567(02-99) Previous Versions Obsolete

Based on observation and interview, the facility

failed to ensure corridors in the means of egress

Event IQ:0BR021

Facility ID: TN3315

If continuation

months and/or until 100%

compliance.

Division of Health Care Facilities  (X1) PROVIDER/SUPPLIER/CL		(X1) PROVIDER/SUPPLIER/CLIA	(XZ) MULTIPLE CONSTRUCTION			SURVEY LETED
ND PLAN O	F CORRECTION	TION IDENTIFICATION NUMBER:		A. SUILDING:		
		7110045	a. Wing		04/	13/2016
		TN3315				
1AME OF PE	KOVIDER OR SUPPLIS	41 1	ADDRESS, CITY, ST			
	AISY HEALTH CA		QUOYAH ROAD -DAIŞY, TN 37:		•	
		STATEMENT OF DEFICIENCIES	(5)	PROVIDER'S PLAN OF CO	DRRECTION	(XS)
(X4) ID PREFIX TAG	/EACH DESIGIS	NOT MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	FREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	EAPPROPRIATE	COMPLETE BATE
*** *** *** *** *** *** *** *** *** **				The Director of Mai will report results of extinguisher un-obs audits to the Quality Assurance Performa Improvement meeti months or until con achieved. Members committee include Director, Director of Administrator and Director of Nursing Development, Soci Dietary Manager, I Manager, Activity Environmental and Mangers.	the fire tructed  ance ing for 3 inpliance is s of the Medical of Nursing, Assistant g Staff al Services, Rehab Director,	5/16/16

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2016 FORM APPROVED <u>OMB NO. 0938-0391</u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	CONSTRUCTION  MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
:		445408	B. WING		04/11/2016
	PROVIDER OR SUPPLIER DAISY HEALTH CARI	E CENTER .	701	EET AODRESS, CITY, STATE, ZIP CODE SEQUOYAH ROAD DDY-DAISY, TN 37379	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	The findings included observation and in Director, during the between 9:00 AM a service corridor has stored by the MDS.  These findings wer Supervisor and ack Administrator during 4/11/16.  NFPA 101 MISCEL OTHER LSC DEFIT This STANDARD is Based on observation and in director on 4/11/16 rated ceiling in the kitchen area was defined to maintain the ceiling was saidled to maintain the string in the kitchen area was defined to maintain the ceiling in the kitchen area was defined to maintain the ceiling was saidled to maintain the ceiling in the kitchen area was defined ceiling was saidled to maintain the ceiling was saidled to maintain the kitchen area was defined ceiling in the kitchen area was defined ceiling was saidled to maintain the ceiling was saidled to maintain the kitchen area was defined to maintai	e:  terview with the Maintenance afacility tour on 4/11/16 and 11:30 AM confirmed the d beds stored and lifts/carts office.  e verified by the Maintenance knowledged by the g the exit conference on  LANEOUS  CIENCY NOT ON 2786 is not met as evidenced by: tion and interview, the facility ne fire resistance rating of fire 1, 8.3.5.1, 19.1.1.1.2)  e:  terview with the maintenance at 10:00 AM revealed the dishwashing room and in the amaged due to water leak. gging and the tape was  re verified by the Maintenance	K 072	1.) The Maintenance Director on April 11, 2016, removed items that were obstructing of impediments to full instant up of egress in the identified are 2.) The Maintenance Director audited the entire facility for obstruction or impediments to full instant use of egress to determine compliance on April 2, 2016.  3.) The Maintenance Director was in-serviced by the administrator on ensuring means of egress shall be continuously maintained free of all obstructions or impediments to full instant up in the case of fire or other emergency on April 26, 2016. The facility did a staff inservice that was completed of April 22, 2016, on 8 foot egress path in all corridors. The preventative maintenance program will include auditing means of egress to ensure there in compliance with maintaining means of egress that are free of all obstruction or impediments to full instantions in the case of fire or other egress to ensure there in compliance with maintaining means of egress that are free of all obstruction or impediments to full instanting insta	all or ise ea. or oril or se g
K 147 SS=F	4/11/16. NFPA 101 LIFE SA	FETY GODE STANDARD	K 147	use in the case of fire or othe emergency.	:F

FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID:0BR021

Facility ID: TN3315

If continuatio

Division of Health Care	Facilities		(X3) DATE SURVEY
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	COMPLETED
MIND LOUIS AL COLLINGS HOW		7. 00,001101	
	TN3315	8. WING	04/13/2016
NAME OF PROVIDER OR SUP		ADDRESS, CITY, STATE, ZIP CODE -	
	701 SEC	QUOYAH ROAD	•
SODDY-DAISY HEALTH		-DAISY, TN 37379	ORRECTION (X5)
SACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST SE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD 85 COMPLETE PROPRIETE CATE
		4.) Audits of the maintenance proginclude means of be performed by Maintenance Dir time 5 days and times 3 weeks an monthly times 2 and/or until 1009  The Director of I will report result coverage audits Assurance Perfo Improvement me months or until cachieved. Members of Members of North Administrator and Director of Nurs Development, S Dietary Manage Manager, Activity and Environment.	gram, which the ector daily then weekly ad then months to compliance.  Maintenance s of sprinkler to the Quality mance teeting for 3 compliance is bers of the de Medical or of Nursing, ad Assistant sing, Staff ocial Services, or, Rehab ity Director,

Division of Health Care Facilities LAB ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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Di <u>vision (</u>	of Health Care Fa	cilities			(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED
		TN3315	B. WING		04/13/2016
 NAME OF P!	ROVIDER OR SUPPLIE	R STREET	LOORESS, CITY, S	TATE, ZIP CODE -	
•	AISY HEALTH CAI	701 SEC	QUOYAH ROAD -DAISY, TN 37:		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST 85 PRECEDED 6Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLET
TAG :	REGULATORY OF	(LSC IDENTIFYING INFORMATION)	· · · · · · · · · · · · · · · · · · ·	DEFICIENCY;	
				K130 1.) The Maintenance contacted Lowes on A 2016 and ordered the 5/8 sheetrock to repla damaged areas identified areas will be repaired by May 15, 2.) The Maintenance audited the entire fact April 12, 2016, for fir resistance barriers con 3.) The Maintenance was in-serviced by the administrator on April 2016, on maintaining resistance rating of fir barriers. The prevent maintenance program include auditing roomensure there in complewith fire resistance rating of the barriers.  4.) Audits of the prevent maintenance program include fire barriers, performed by the Ma	April 15, needed nee the fied. nee 2016. Director fility on re ncerns. Director e il 26, the fire re sative i will is to liance stings of rentative i, which will be
:	:		;	Director daily time 5 then weekly times 3 then monthly times 2 and/or until 100% co	days and weeks and months
			,		;
	!				<u>:::::::</u>

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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Division of Health Care Fac TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. SUILDING: _		COME	PLETED
	TN3315	8. WING		04/	13/2016
VAME OF PROVIDER OR SUPPLIER		ODRESS, CITY, ST			
 SODDY-DAISY HEALTH CAR	701 SEC	QUOYAH RÓAD -DAISY, YN 373			
CACH DESIGNANCE	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IN SHOULD BE IE APPROPRIATE	COMPLETE
			The Director of M will report results barriers audits to the Assurance Perford Improvement meet months or until control of Members of Members of Members of Director, Director, Administrator and Director of Nursing Development, Son Dietary Manager, Manager, Activity and Environment.	laintenance of fire he Quality nance sting for 3 mpliance is ers of the Medical of Nursing, I Assistant ng, Staff cial Services, Rehab y Director,	5/16/16

STATE FORM

PRINTED: 04/13/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA-(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445408 B. WING 04/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 SEQUOYAH ROAD SODDY-DAISY HEALTH CARE CENTER SODDY-DAISY, TN 37379 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 147 Continued From page 3 K 147: K147 Electrical wiring and equipment shall be in 1.) The Maintenance Director did accordance with National Electrical Code, 9-1,2 the following things to resolve the (NFPA 99) 18.9.1, 19.9.1 outstanding items: (1) on April 11, This STANDARD is not met as evidenced by: Based on observation and interview, the facility 2016 removed all power strips and failed to maintain electrical equipment. medical equipment was plugged into outlets (2) on April 18, 2016 The findings include: red tape was placed at all electrical panels indicating the 3 foot barrier Observation and interview with the maintenance (3) on April 25, 2016, Ceiling light director on 4/4/16 between 10:00 AM and 1:30 was replaced with a new 4 foot PM confirmed; LED light purchased from Lowes Bed in physical therapy was plugged into a on April 15, 2016. power strip. 2.) The Maintenance Director Two separate oxygen concentrators were audited the entire facility to ensure plugged into power strips in physical therapy. compliance on April 12, 2016, for Power strips were plugged into each other in (1) power strips, (2) 3 foot clear physical therapy behind the computer work space in front of electrical panels station. and (3) missing light fixtures with 4. No 3' clear space in front of electrical panels the wires exposed. in east and west wing electrical rooms and in 3.) The Maintenance Director was in-serviced by the administrator on A ceiling mounted fluorescent light fixture had National Electrical Code, 9-1.2 been removed in the laundry, and the wires were hanging exposed. (NFPA 99) 18.9.1, 19.9.1 on April These findings were verified by the Maintenance 26, 2016. The preventative Supervisor and acknowledged by the maintenance program will include Administrator during the exit conference on auditing rooms to ensure there in 4/11/16. compliance with electrical equipment.

STATE FORM

PRINTED: 04/18/2016 FORM APPROVED

Division	of Health Care Faci	lities			
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			İ		
		TN3315	B. WING		04/13/2016
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	STATE, ZIP CODE -	
SQDQY-E	DAISY HEALTH CAR	CENTER	UOYAH ROA! DAISY, TN 37		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST 85 PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JUD BE COMPLETS
Division of	Health Care Facilities			4.) Audits of the preventative maintenance program, which include electrical equipment, be performed by the Maintena Director daily time 5 days and weekly times 3 weeks and the monthly times 2 months and/o until 100% compliance.  The Director of Maintenance report results of electrical equipment audits to the Qualit Assurance Performance Improvement meeting for 3 months or until compliance is achieved. Members of the committee include Medical Director, Director of Nursing, Administrator and Assistant Director of Nursing, Staff Development, Social Services Dietary Manager, Rehab Man Activity Director, and Environmental.	will ince i then or will ty
LABORATOR	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	10.001

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